No. 83-2136

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

STATE OF CONNECTICUT,
DEPARTMENT OF INCOME MAINTENANCE,
Petitioner,

v.

MARGARET M. HECKLER, SECRETARY,
AND THE UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES,
Respondents.

On Writ Of Certiorari To
The United States Court Of Appeals
For The Second Circuit

REPLY BRIEF FOR PETITIONER

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Respondents have put forward a flawed analysis of the Social Security Act

provisions in question in this case. Connecticut submits this reply brief to show the deficiencies in the respondents' argument and how they confirm the correctness of the State's position.

I. RESPONDENTS' ERRONEOUS APPROACH TO THIS CASE

A. The Incorrect Premise That Congress Adopted a "Blanket Prohibition" on Federal Support for Care of the Mentally Ill

Respondents repeat the error of the court below by resting their case on the premise that Congress made a conscious judgment when the Social Security Act was initially adopted not to undertake financial support for any care of the mentally ill under the public assistance titles, choosing instead to leave this "fiscal responsibility" with the states. Resp. Br. 15. Respondents broadly define that antecedent bar as a "blanket prohibition against funding for the mentally ill"

(ibid.), and they reiterate the "blanket" nature of the supposed ban. Id. at 15, 16, 25; also at 44. They then proceed to refer to certain respects in which the Social Security Act was subsequently modified to embrace care of the mentally ill in specifically defined circumstances, find no such change for under-65 year-old residents of ICFs specializing in care of the mentally ill, and conclude that the perceived antecedent bar defeats claims for federal funds in such circumstances. Id. at 15-17.[1]

The trouble is that respondents' premise is plainly wrong. There has never been a "blanket prohibition against funding for the mentally ill," and respondents

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[1] Respondents seek to bolster their position by asserting that "Congress has never taken any affirmative action to provide blanket Medicaid coverage for the treatment of [the] mental conditions" of the mentally ill between the ages of 21 and 64. Resp. Br. 16.

cannot, and do not, cite anything (other than the IMD clause itself, the very provision whose meaning this case seeks to determine) in support of any such "blanket" determination.

Far from imposing any "blanket" prohibition, Congress from the beginning has included the mentally ill among those to be covered by Social Security Act public assistance programs. The initial program of aid to the aged contained in the 1935 Act (Title I) extended to any needy person aged 65 or over, whether or not mentally ill. The only exception was for persons in public institutions of any kind. Thus, for example, elderly mentally ill people residing in private institutions, as well as those not institutionalized, were eligible for coverage under the initial law. Titles IV (Aid to Dependent Children) and X (Aid to the Blind) similarly extended

to all who qualified, whether or not they were mentally ill.

Likewise, when the Act was amended in 1950 to provide assistance to the disabled, those with mental impairments as well as those with physical impairments were covered. See 45 C.F.R. § 233.90 (1984). At the same time, the Title I program of aid to the aged was modified to embrace medical expenses, and enlarged to permit coverage of persons in public medical institutions. In connection with these new or expanded programs, Congress adopted an exception for patients in IMDs, and in medical hospitals with psychosis or tuberculosis diagnoses.[2] This was avowedly an exception, applicable to residents of certain facilities, from

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[2] The exception also applied to residents of tuberculosis institutions.

general coverage for the mentally ill that met the eligibility requirements of the programs, and did not represent any "blanket" prohibition on coverage of the mentally ill, who as a class had been included from the beginning in the beneficial assistance programs of the Act.[3] Thus, the meaning and scope of the IMD clause cannot be resolved by reference to a supposed "blanket prohibition" on funding for the mentally ill; respondents' faulty reliance on this non-existent prohibition cannot substitute for analysis of the IMD clause itself.

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[3] Respondents repeatedly refer to the states' "long-standing responsibility for the care of the mentally ill." Resp. Br. 28; also 15, 44. But apart from those residing in state mental hospitals, the needy mentally ill were no more the responsibility of states than were other needy citizens embraced within the public assistance titles, all of whom states had sought to aid to the extent of their abilities. See H.R. Rep. No. 615, 74th Cong., 1st Sess. 4, 10 (1935).

B. The Erroneous Refusal To Accept the Facility-Based Distinction Adopted By Congress

Since the task of interpreting the IMD clause in the Medicaid law cannot be avoided by assuming the result, as respondents seek to do, there must be an objective assessment of what Congress meant when it adopted that exception to its general coverage provisions. Such an assessment reveals, as shown in petitioner's opening brief, that the exception was motivated by an aversion to supporting mental hospitals. That judgment was based on a century of experience with state mental hospitals, and was confirmed by the seminal Congressionally-commissioned five-year study of mental health in America, which emphasized how outmoded these institutions had become.

Respondents ignore all of this history in their brief. Instead, they disparagingly

characterize the distinction based on the nature of the institutional setting as "artificial" and "single-minded," and argue that coverage should turn on the nature of the patients involved. Resp. Br. 27. Though respondents would belittle a coverage test based on the type of facility in which a person resides, this is the distinction that Congress made, and respondents ultimately so acknowledge when they say that "the statute merely limits the types of facilities in which [the mentally ill] may receive covered services." Id. at 39.[4]

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[4] This statement is also at odds with respondents' earlier argument (Resp. Br. 15-16) to the effect that there was a "blanket prohibition" on funding services "for any category of the mentally ill."

Respondents say the facility-oriented distinction creates "financial disincentives" to the improvement of state mental hospitals. Resp. Br. 26-27. But Congress considered this issue, and concluded that the Long Amendment, which offered federal support for mental hospitals for people over 65 if a number of programmatic conditions were satisfied, would afford ample incentive for improvement. Whatever changes have taken place in mental hospital characteristics along the lines emphasized in respondents' brief (pages 35-36) occurred during the time the states were claiming and receiving federal support for ICFs that respondents now seek to classify as IMDs, thus confirming both the success of the Congressional initiative

and the hollowness of respondents' argument.[5]

Respondents criticize petitioner's interpretation because it distinguishes between free-standing ICFs (which are not IMDs) and hospital-based ICFs (which can be). Resp. Br. 27. Respondents simply assert that the services offered by the two types of facilities are "identical." Yet the Congressional exception rests on the contrary premise -- that state mental hospital characteristics were unique. This was surely a valid judgment for

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[5] Respondents also advance a reductio ad absurdum to the effect that Connecticut's approach would preclude federal funding for a mental hospital even if it were to give itself over entirely to providing ICF or SNF levels of care. Resp. Br. 27. There is no evidence that such a transformation of any state mental hospital has occurred, so that this theoretical logical conundrum does not detract from the Congressional judgment that mental hospitals as a group deserved different treatment than other institutional facilities, in light of their unique characteristics. Cf. Schweiker v. Wilson, 450 U.S. 221 (1981).

Congress to make, given the well-documented history of that singular phenomenon.[6]

Finally, respondents' approach produces the truly arbitrary result that a mentally ill person can qualify for Medicaid while being treated in a general hospital yet lose eligibility when transferred to a nursing home that specializes in the care of the mentally ill. See Resp. Br. 39.

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[6] Respondents evidence a true failure to grasp the distinctions made by Congress when they seek to equate service provided to the mentally ill in a mental hospital and in an ICF (Resp. Br. 43), even though there are significant differences in the levels of care provided in the two categories of facilities. See Pet. Br. 51, n.38, 115-116, n.88. That is why respondents' duck-chicken analogy is inapt. The more pertinent analogy, apropos of respondents' arguments, is to the ostrich.

C. The Unsupported Efforts To Narrow the Unconditional ICF Definition

In the end, despite aggressive advocacy,[7] respondents cannot avoid the specific statutory provision that defines an ICF qualifying for federal support as an institution caring for those requiring the specified level of care because of their physical or mental condition. 42 U.S.C. § 1396d(c). They present the question as whether this unconditional provision "supersedes the blanket IMD provision" (Resp. Br. 25); but as has been shown, there is no basis for the "blanket" sobriquet. Respondents' further efforts to explain away the ICF definition

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[7] See, for example, Resp. Br. 24 ("In the absence of any statutory provision that supports [Connecticut's] position"); id. at 23 ("Connecticut does not point to a single section of the Medicaid statute that refutes the plain meaning of the sections described above").

are as weakly stated and as unpersuasive as were the similar efforts of the court below. They say the provision is "susceptible to an interpretation" consistent with the Secretary's reading, because the reference to persons with mental conditions "most probably" refers to aged patients with mental illness, or "also may apply" to the mentally retarded. Resp. Br. 25-26. These tentative assertions depend upon reading into the statute qualifying words that are not there. Nor were the qualifications intended. From the time that ICFs were first brought into the Act in 1967, Congress meant them to provide for persons with physical or mental conditions, without qualifications, because there was a perceived need for the type of service that ICFs provide for such needy persons. Pet. Br. 46-47.

II. FISCAL IMPLICATIONS OF THE OUTCOME OF THIS CASE

Respondents refer to the "staggering" impact of acceptance of Connecticut's position in this case. Resp. Br. 17. That is a red herring. The real staggering impact would be on the states if the federal position were to prevail, for states would have to raise and return to the federal government tens if not hundreds of millions of dollars in funds long since received and expended in the care of needy nursing home residents. On the other hand, if respondents prevail, the federal government will enjoy an unexpected return from the many states that have drawn Medicaid funds over the past decade to help finance the care of persons in nursing homes that may now be found to be IMDs. There is certainly no basis for any claim of dire impact on the

federal fisc should the State's position prevail here.[*]

III. RESPONDENTS' INCORRECT STATUTORY ANALYSIS

Respondents argue that their position is supported by statutory wording, legislative history and regulations. They are incorrect in all three instances.

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[*] To the extent states have continued to receive federal funds for facilities that may be determined to be IMDs, there is obviously no additional exposure beyond what the federal government has paid for as long as the facilities have been participating in the program. To the extent (if at all) that states have failed to certify facilities for program participation because of the concern that they might be classified as IMDs, there can be no claim for federal participation, for certification is a condition precedent to participation. 42 C.F.R. § 442.12 (1983).

There could be facilities that are certified but for which states have suspended claims for federal funding, at least pending the outcome of this case. But even if such situations exist, the federal exposure is limited because of the provision, enacted in 1980, barring payment of any claim for federal financial participation not filed within two years of the expenditure by the state. Pub. L. No. 96-272, § 306, 94 Stat. 530 (1980).

A. The Terms of the Medicaid Statute

As anticipated, respondents rely primarily on the section of the statute listing covered Medicaid services (42 U.S.C. § 1396d(a)), particularly subsection (15). Subsection (15) refers to ICF services other than such services in an IMD.[9] Petitioner's opening brief showed that the IMD phrase in this subsection referred to ICF-type services provided in mental hospitals, and cited the pertinent legislative history showing that the addition of this phrase was meant to assure that

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[9] See also subsection (14) which also speaks of ICF services. Likewise, the definition from the Handbook of Public Assistance in 1966 on which respondents rely (Resp. Br. 42) is of "Skilled Nursing Home Services" (emphasis supplied).

The Medicaid provisions on skilled nursing facilities (42 U.S.C. § 1396a(a)(28)) adopt the Medicare definition for skilled nursing facility except for the exclusion for institutions which are primarily for the care and treatment of mental diseases. These institutions are embraced within the Medicaid program. Cf. 42 U.S.C. § 1395x(j).

such services in mental hospitals, though permitted, were not mandatory (even though coverage of hospital services generally was mandatory). Pet. Br. 67-68.[10]

This meaning was confirmed specifically as to ICFs in 1972. When ICFs were brought under the Medicaid program in 1971, there was an inadvertent failure to amend subsection (15) of the list of covered services, which theretofore had listed inpatient hospital and skilled nursing facility services for persons aged 65 and over in IMDs as covered services. The omission was corrected by a technical amendment in 1972,[11] originating in the Senate Finance Committee, which described the change as clarifying that

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[10] Respondents do not mention the latter evidence.

[11] Social Security Act Amendments of 1972, Pub. L. No. 92-603, § 297, 86 Stat. 1459-60 (1972).

ICF services are to be covered "for individuals 65 and over in mental institutions, as well as inpatient hospital services and skilled nursing home services." S. Rep. No. 1230, 92d Cong., 2d Sess. 321 (1972).[12]

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[12] Respondents cite the conference report description of this technical provision as indicating that ICFs as well as SNFs and hospitals can be IMDs. Resp. Br. 31. But as the District Court so clearly demonstrated (Pet. App. 18c), the brief excerpt in the conference report was inaccurate. The conference report erroneously describes the technical amendment as requiring coverage of ICF services in IMDs if a state covers hospital and skilled nursing home services in IMDs. The amendment does not so provide, and has not been so construed by DHHS. The conference report mistakenly included its discussion of this amendment under a heading applicable only to Medicare provisions. These errors presumably occurred because of the end-of-session rush. The conference committee reached agreement on the 165-page bill and ordered printing of a conference report on Saturday, October 14, 1972. H. R. Rep. No. 1605, 92d Cong., 2d Sess. 1 (1972). The House and Senate each accepted the conference proposal on the following Tuesday, October 17, 1972, the day before Congress adjourned for the year. 118 Cong. Rec. 36914, 36936. It is apparent that the conference report summary of this technical change, which received no significant attention during the conference of

(footnote cont'd)

Respondents also find comfort in the 1972 change that extended Medicaid coverage to services provided in "psychiatric hospitals" for children, contending that the term "psychiatric hospital" would not have been used had the term IMD been recognized as applying only to mental hospitals. Resp. Br. 23. This argument fails because the 1972 amendment did not extend to all mental hospitals, but only to those that met a number of specific criteria included in the statute. Congress used the term "psychiatric hospital" to refer to those hospitals that satisfied the special criteria.

(footnote cont'd)

the two Houses, is not a reliable source for determining the meaning of the Medicaid provision at issue in this case.

B. Legislative History -- The Long Amendment and Later Proposals

An important element in Connecticut's case is the showing that the Long Amendment, adopted as part of the original Medicaid Act in 1965, sharply distinguished between IMDs, on the one hand, and alternatives, including nursing homes, on the other hand. See Pet. Br. 44-45, 51-52. Respondents attempt to brush aside the significance of this section of the law by arguing that the Long Amendment applies only to the elderly. Resp. Br. 18, 29, 32. Yet this response misses the point. Even if the Long Amendment provisions were confined to the elderly, they demonstrate that Congress understood and treated nursing homes (SNFs and later ICFs) as distinct from, and not a category within, IMDs. That is why the Long

Amendment so strongly supports the interpretation advanced by petitioner. Respondents fail to appreciate its significance because of their unwarranted premise that the IMD clause reflects an antecedent Congressional decision to exclude all coverage of the mentally ill. Yet the Long Amendment confirms what is already demonstrated by the history of the Act -- that the IMD clause itself was a confined exception to the principle that the public assistance provisions were available to all persons in the need categories without differentiation based on the nature of affliction.

In an effort to avoid the impact of the Long Amendment, respondents refer to articles critical of the care provided in some nursing or boarding facilities or "welfare hotels" and argue from them that Congress would not "have wanted Medicaid

funds to go to 'alternative' facilities that were no better than the traditional institutions they were replacing." Resp. Br. 38. Perhaps so. But not all boarding or nursing facilities qualify for Medicaid participation, and certainly "welfare hotels" do not. Department rules specify in elaborate detail the conditions of participation for ICFs and SNFs. They cover program requirements as well as physical environment, staffing, residential services, and safety conditions. See 42 C.F.R. Part 442, Subparts D, E, and F (1983). General references to poor care in some "alternative" facilities do not help resolve the issue presented here -- whether a facility that meets the

elaborate federal standards qualifies for Medicaid.[13]

Respondents adopt the error of the court below and attempt to rely on post hoc evidence of Congressional refusal to modify the IMD clause despite pleas that it do so in 1967, 1970 and 1972. Resp. Br. 18, 30, 31, 32. Evidence of what Congress later failed to do is a suspect method of construing what Congress actually did earlier. See ICC v. Railway Labor Executives Association, 315 U.S.

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[13] To the extent pertinent, respondents' articles undermine the DHHS position. One study is quoted as finding that "psychiatric disturbances are probably the predominant form of illness in nursing homes, and yet psychiatric care in these homes is generally deficient." Resp. Br. 38, n.29. Yet, respondents' position would deter correction of this perceived problem by denying federal support to the very homes trying to solve the problem by specializing in care for the mentally ill.

373, 378-80 (1942).[14] "If the failure of enactment of every amendment offered for the consideration of Congress were necessarily held to shed light on the legislation sought to be amended, the search for Congressional intention would be endless and fruitless." United States v. Guerlain, Inc., 155 F. Supp. 77, 82 (S.D.N.Y. 1957).

Here, there is an even greater flaw. The proposals that were not accepted did not relate to the issue now before the Court. The proponents of change were seeking full Medicaid coverage for mental hospitals, as the quoted excerpts in respondents' brief suggest

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[14] In that case, the Court said that a conclusion that Congress' failure to amend certain statutory provisions (despite requests that it do so) demonstrated an intent to ratify the ICC's construction of those provisions would be "the product of a set of inferences none of which is free from doubt." Id.

and as has been clearly shown in petitioner's brief, at pages 84-92. Particularly inapt is the 1970 incident, which respondents mistakenly describe as an effort to secure coverage for the mentally ill in ICFs (Resp. Br. 31) but which was in fact an effort to resist a new provision that would have precluded any Medicaid for residents of public ICFs for the mentally retarded. See Pet. Br. 88-89. This is clearly shown in the hearing record at the pages cited by respondents and the exhibit referred to in the testimony on those pages. Social Security Amendments of 1970: Hearings Before the Senate Comm. on Finance on H.R. 17550, 91st Cong., 2d Sess. 502-506, 520 (1970).

C. The Unaltered Department Regulations

Petitioner showed that the current Departmental interpretation of the IMD clause is contrary to the interpretation

adopted at the time Medicaid was first enacted and maintained thereafter for many years. Pet. Br. 72-78. Respondents implicitly recognize the correctness of this showing, which was based in part on the regulation adopted immediately after the Act was passed defining an IMD eligible to participate with respect to persons aged 65 and over solely in terms of a mental hospital. But respondents attempt to dismiss the significance of this action by saying that as SNFs and ICFs specializing in the care of the mentally ill "became increasingly common," that limiting regulation was dropped. Resp. Br. 43.

Respondents have apparently been misled by the rearrangement of the Department's regulations over the past decade. The original regulation has not been dropped. It remains in effect and is

contained in 42 C.F.R. § 440.140(a)(1)(ii).[15] Thus, the point previously made remains -- under the view now espoused by respondents, persons over 65 could not receive medical assistance in ICFs and SNFs specializing in their care, because those facilities would not meet the IMD standard of 42 C.F.R. § 440.140(a)(1)(ii). Thus would the respondents' approach achieve the ultimate reversal of the policy objectives of the Long Amendment.[16]

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[15] The regulation requires that a qualifying IMD meet the standards of 42 C.F.R. §§ 405.1035 and 405.1036. These sections, particularly § 405.1036 (and sections 405.1037 and 405.1038 which it incorporates by reference) set forth the standards that must be met for a facility to qualify as a psychiatric hospital under the Medicare program.

[16] Respondents' brief fails to cite or mention the 1971 Department report to Congress describing nursing home services for the mentally ill as among those available for which Medicaid support is available (see Pet. Br. 75-77 and App. C) -- still further evidence of the contemporaneous understanding within the Department that the IMD provision was confined to mental hospitals.

D. Community Mental Health Center Legislation

Respondents try to advance the Community Mental Health Center (CMHC) legislation as the Congressional substitute for care of the mentally ill between ages 21 and 64. Resp. Br. 39-41. This effort does not avail. The CMHC program's primary purpose was to grant funds for construction of mental health centers (although for some years funds for staffing and operations were also provided). No means testing is involved, and there is no reimbursement for the cost of patient care. Contrary to respondents' assertion (Resp. Br. 41), when Congress cut back on the funding of CMHCs, it affected all users, not just those aged 21 to 64. The CMHC legislation provides no support for respondents' interpretation of the IMD provision of the Medicaid law.

IV. THE PROPRIETY OF THE "PENNHURST" ARGUMENT

Lastly, respondents assert that the argument in Section III of petitioner's brief cannot be considered because it seeks to raise a ground for reversal not encompassed within the "Question Presented" in the Petition for Writ of Certiorari. Resp. Br. 48. We think this mischaracterizes the argument.[17] Petitioner does not challenge the power of Congress to adopt an explicit IMD provision that fits respondents' interpretation. But Congress has not done so. Rather, DHHS adopted an approach that made it difficult if not impossible for a state to know until after the fact whether a facility would be covered by the IMD

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[17] Petitioner's summary of the argument may well have led respondents to make this point. See Pet. Br. 19-21.

exception.[18] Because this approach is so inconsistent with the principles underlying the Pennhurst decision, it ought not be attributed to Congress in the absence of the most compelling evidence. This is the essence of the argument in Section III. It is supported by the well-accepted maxim that statutes are construed where possible to avoid potentially serious constitutional issues. See Califano v. Yamaski, 442 U.S. 682, 692-93 (1979); St. Martin Evangelical Lutheran Church v. South Dakota, 451 U.S. 772, 780 (1981).

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[18] Respondents seek to avoid this conclusion by relying on Connecticut's awareness in 1976 that an issue had been raised about extending the IMD clause to SNFs and ICFs. See Pet. Br. 95, n.74; Resp. Br. 49. But knowing that the issue was presented was not equivalent to knowing how it would be resolved or how DHHS might apply its new policy. As shown previously (Pet. Br. 94-102), Connecticut could not reasonably have known the outcome of the audit of Middletown Haven until the result was announced.

As such, Section III is directly related to the "Question Presented" and is properly before the Court.

CONCLUSION

For the foregoing reasons and those set forth in petitioner's opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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